MARKET CONDUCT EXAMINATION REPORT
Dated September 27, 2012

COVERING THE TIME PERIOD OF JANUARY 1, 2009 THROUGH DECEMBER 31, 2009

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC.

2775 Crossroads Blvd., PO Box 10600
Grand Junction, CO 81502-5600

NAIC Company Code 95482
NAIC Group Code 1184

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC.

MARKET CONDUCT EXAMINATION REPORT

Dated September 27, 2012

COVERING THE TIME PERIOD OF JANUARY 1, 2009 THROUGH DECEMBER 31, 2009

Examination Performed by:

State Market Conduct Examiners

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COMPANY PROFILE

The following profile is based on information provided by Rocky Mountain Health Maintenance Organization, Inc. and has not been independently verified by the Division of Insurance:

Rocky Mountain Health Maintenance Organization, Inc. (Rocky Mountain HMO) is an independent, nonprofit, IPA-model health maintenance organization, which became licensed and began operation in Grand Junction (Mesa County) Colorado on June 24, 1974.

Operations

Rocky Mountain HMO operates only in Colorado. Headquarters are located in Grand Junction, Colorado. The company is certified to operate in all Colorado counties except Baca. The organization has branch offices in Denver, Pueblo and Durango. Accounting records are maintained in the corporate office in Grand Junction, Colorado.

Rocky Mountain HMO provides health care benefits to large and small employer groups, Medicare and Medicaid recipients and to children enrolled in the CHP+ program. The company contracts with individual physicians, physician groups and physician practice associations, hospitals and other health care providers to provide health care services to its members. The payment methods used for payment of physicians and other health care providers include negotiated fee for service rates, capitation rates, case rates and per diem rates. Rocky Mountain HMO contracts with over 10,000 physicians and providers statewide.

Rocky Mountain HMO operates under the trade name Rocky Mountain Health Plans.

Organizational Structure

Rocky Mountain HMO is a federal 501(c) (4) tax exempt organization and a Colorado nonprofit corporation. Rocky Mountain HMO is federally qualified and has a certificate of authority from the Colorado Division of Insurance to operate as a health maintenance organization. Rocky Mountain HMO operations are directed by a community Board of Directors.

Rocky Mountain HMO is the sole member of Rocky Mountain HealthCare Options, Inc. (RMHCO), a nonprofit hospital, medical-surgical health service corporation and owns 100 percent of the stock in CNIC Health Solutions (CNIC), a self-funded employer group administrator. A relational chart and description are shown below.

Description of Relational Chart

Rocky Mountain Health Maintenance Organization, Inc.
Colorado Nonprofit Organization – FEIN 84-0614905
NAIC Code 95482
State of Domicile – Colorado

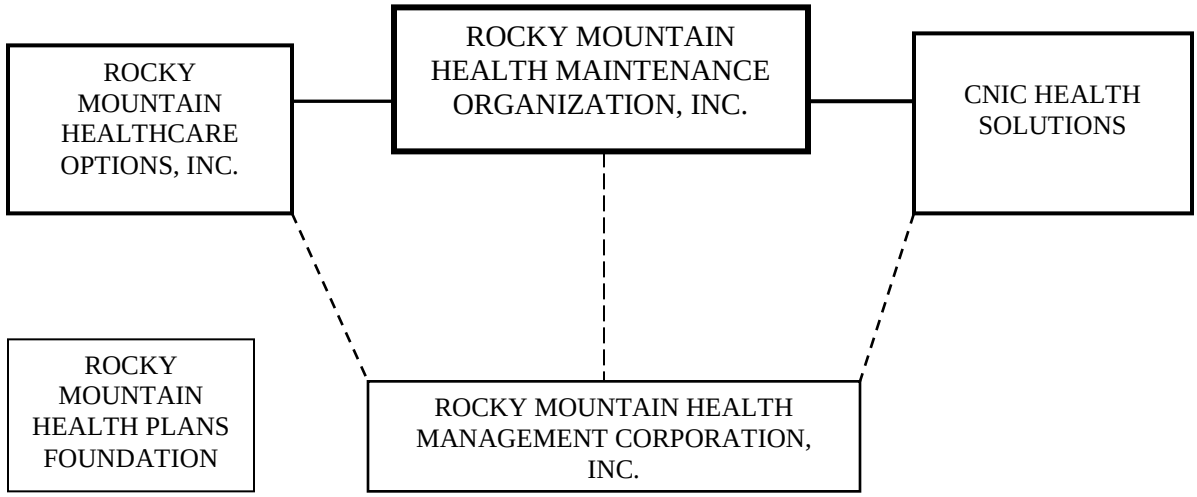
Rocky Mountain HealthCare Options, Inc.
Colorado Nonprofit Hospital, Medical/Surgical and Health Service Corporation – FEIN 84-1224718
NAIC Code 47004
State of Domicile – Colorado

Rocky Mountain Health Maintenance Organization, Inc. is the only member of Rocky Mountain HealthCare Options, Inc.

CNIC Health Solutions, Inc.
Colorado Corporation – FEIN 71-0873411

Rocky Mountain Health Maintenance Organization, Inc. owns 100% of the outstanding stock of CNIC Health Solutions, Inc.

ORGANIZATIONAL CHART



Ownership ——
Contractual Relationship - - - - - -

The following shows Rocky Mountain HMO's written premium and market share for the period under examination:

Premium and Market Share as of December 31, 2009:

Individual:	$1,650,583*
Small Group:	$79,153,555*
Large Group:	$77,342,294*
Total Written Premium:	$158,146,433*
Total Accident and Health Market Share:	2.24%**

* As reported by Rocky Mountain HMO
**As shown in the 2009 Edition of the Colorado Insurance Industry Statistical Report

PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance ("Division"), who were assisted by independent contract examiners, reviewed certain business practices of Rocky Mountain Health Maintenance Organization, Inc. ("Rocky Mountain HMO" or "Company"). This market conduct examination ("MCE") was conducted in accordance with Colorado insurance laws, §§ 10-1-203, 10-1-204, and 10-1-205, as well as §§ 10-3-1106 and 10-16-416, C.R.S., which empower the Commissioner of Insurance ("Commissioner") to examine any entity engaged in the business of insurance in the State of Colorado.

The purpose of this examination was to determine Rocky Mountain HMO's compliance with Colorado insurance laws related to health maintenance organizations. Examination information contained in this report will serve only this purpose except as provided by law pursuant to §§ 10-1-204 and 205, C.R.S. The findings and conclusions, including the Final Agency Order, arising out of this examination shall be a public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners ("NAIC"). They relied primarily on records and materials maintained and/or supplied by Rocky Mountain HMO. The MCE covered the period from January 1, 2009, through December 31, 2009.

The examination included review of the following:

Company Operations and Management
Complaints
Producers
Forms
Rating
New Business Applications and Renewals
Cancellations/Declinations/Nonrenewals/Rescissions
Claims
Utilization Review

The examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for Rocky Mountain HMO identifying any concerns and/or discrepancies. The comment forms contained a section that permitted Rocky Mountain HMO to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to health insurance laws as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division. The examiners may not have discovered all unacceptable or non-complying practices of Rocky Mountain HMO. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company, HMO or insurance company or HMO product.

METHODOLOGY

The examiners reviewed Rocky Mountain HMO's business practices concurrently with an examination of Rocky Mountain HealthCare Options, Inc. ("Rocky Mountain HCO").

At the beginning of the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although Rocky Mountain HMO and Rocky Mountain HCO are separate companies, there are certain policies, procedures and data systems that are common to both companies.

Therefore, it was agreed that in cases involving claims, utilization review, and some underwriting processes, the Division would "deem" the findings applicable to Rocky Mountain HCO, even though the actual findings may have been identified in only Rocky Mountain HMO. During the examination period, Rocky Mountain HMO was not actively marketing individual health plans. The examiners reviewed no individual new business applications for Rocky Mountain HMO.

The examiners reviewed Rocky Mountain HMO's business practices to determine compliance with Colorado insurance law as outlined below.

Statute or Regulation	Subject
Section 10-2-401, C.R.S.	License required.
Section 10-2-702, C.R.S.	Commissions.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age – coverage for students who take medical leave of absence.
Section 10-16-104.5, C.R.S.	Autism – treatment – not mental illness.
Section 10-16-104.7, C.R.S.	Substance abuse - court-ordered treatment coverage.
Section 10-16-104.8, C.R.S.	Mental health services coverage - court-ordered.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic health benefit plans - rules - benefit design advisory committee - repeal.
Section 10-16-105.2, C.R.S.	Small employer health insurance availability program.
Section10-16-105.5, C.R.S.	Individual health plans – federally eligible individuals – limited guarantee issue.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-106.7, C.R.S.	Assignment of health insurance benefits.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain.
Section 10-16-107.2, C.R.S.	Filing of health policies.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-108.3, C.R.S.	Continuation privilege – special election period – notice requirements – definitions – repeal.
Section 10-16-108.5, C.R.S.	Fair marketing standards.
Section 10-16-109, C.R.S.	Rules and regulations.
Section 10-16-112, C.R.S.	Private utilization review – health care coverage entity responsibility.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – internal review - rules.

Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-121, C.R.S.	Required contract provisions in contracts between carrier and providers.
Section 10-16-125, C.R.S.	Reimbursement to nurses.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modifications of health benefit plans.
Section 10-16-401, C.R.S.	Establishment of health maintenance organizations.
Section 10-16-403, C.R.S.	Powers of health maintenance organizations - repeal.
Section 10-16-406, C.R.S.	Evidence of coverage.
Section 10-16-407, C.R.S.	Information to enrollees.
Section 10-16-409, C.R.S.	Complaint System.
Section 10-16-413, C.R.S.	Prohibited practices.
Section 10-16-416, C.R.S.	Examination.
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Section 10-16-706, C.R.S.	Intermediaries.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act"
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-1	Replacement Of Individual Accident And Sickness Insurance.
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care
Insurance Regulation 4-2-9	Concerning Non-Discriminatory Treatment Of Acquired Immune Deficiency Syndrome (Aids) And Human Immunodeficiency Virus (HIV) Related Illness By Life And Health Carriers
Insurance Regulation 4-2-11	Rate Filing Submissions For Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-15	Required Provisions In Carrier Contracts With Providers, Carrier Contracts With Intermediaries Negotiating On Behalf Of Providers, And Carrier Contracts With Intermediaries Conducting Utilization Reviews
Insurance Regulation 4-2-16	Women's Access To Obstetricians, Gynecologists And Certified Nurse Midwives Under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation Of Health Plan Claims Involving Utilization Review And Denial Of Benefits
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued to Self-Employed Business Groups of One

Insurance Regulation 4-2-20	Concerning the Colorado Comprehensive Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review Of Benefit Denials Of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements For Health Carriers
Insurance Regulation 4-2-27	Procedures For Reasonable Modifications To Individual And Small Group Health Benefit Plans
Insurance Regulation 4-2-28	Concerning The Payment Of Early Intervention Services For Children Eligible For Benefits Under Part C Of The Federal "Individuals With Disabilities Education Act"
Insurance Regulation 4-2-30	Concerning Rules For Complying With Mandated Coverage Of Hearing Aids And Prosthetics
Insurance Regulation 4-6-2	Group Coordination Of Benefits
Insurance Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Emergency Insurance Regulation 08-E-12 (1-1-09)	Concerning Small Employer Group Health Benefit Plans And The Basic And Standard Health Benefit Plans
Insurance Regulation 4-6-5 (2-1-09)	Concerning Small Employer Group Health Benefit Plans And The Basic And Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting For Small Group Health Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Concerning Conversion Coverage
Insurance Regulation 4-6-12	Mandatory Coverage Of Mental Illnesses Pursuant To § 10-16-104(5) And (5.5), C.R.S., For Small Group Policies.
Insurance Regulation 4-7-1	Health Maintenance Organizations
Insurance Regulation 4-7-2	Concerning The Laws Regulating Health Maintenance Organization Benefit Contracts And Services In Colorado
Insurance Regulation 6-2-1	Complaint Record Maintenance

Prior Examinations

Rocky Mountain HMO was the subject of a previous market conduct examination which included a report dated March 24, 2006, for the time period of January 1, 2004, through December 31, 2004.

Sampling Methodology

Rocky Mountain HMO provided three (3) unique populations of underwriting, claims and utilization review files as identified in advance by the Division. The examiners used ACL™ software to select random samples from each of those unique populations for review in accordance with the sampling methodology and sample sizes as set forth in the 2010 NAIC Market Regulation Handbook (Handbook).

In some instances, Rocky Mountain HMO was afforded the opportunity to agree that the findings in the initial sample were representative of the overall population or to request that an additional sample be selected. Rocky Mountain HMO in all instances agreed that an addition sample did not need to be reviewed.

An error tolerance level of seven percent (7%) for claims and ten percent (10%) for other areas was established per the Handbook to determine reportable exceptions.

An error tolerance of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance was applied to identify possible system errors.

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, claims and underwriting guidelines/procedures, and timely cooperation with the examination process.

Complaints

The examiners reviewed the records of complaints received by Rocky Mountain HMO and compared those records with the Division's records to verify accuracy in maintaining complaint records.

Producers

The examiners reviewed the licensing status of the submitting producers for the samples of the files selected in the new business applications and renewal sections of the examination for compliance with the appropriate Colorado insurance law.

Forms

The examiners reviewed forms used in the business practices of the Company as well as the following contract forms, endorsements, and disclosure forms in use during the examination period for compliance with Colorado insurance law:

Form Name	Form Number	Edition Date
ROCKY MOUNTAIN GOOD HEALTH HEALTH MAINTENANCE ORGANIZATION LIMITATIONS AND EXCLUSIONS	L&E-Good Health HMO-109	2009
ROCKY MOUNTAIN GOOD HEALTH HEALTH MAINTENANCE ORGANIZATION HEALTH BENEFITS CONTRACT	HMO-2009-GH/HMO-G-HBC-01-109	2009
ROCKY MOUNTAIN GOOD HEALTH HEALTH MAINTENANCE ORGANIZATION HEALTH BENEFITS CONTRACT	HMO-2008-GH/HMO-G-CS/1000/70-01-308	2008
ROCKY MOUNTAIN GOOD HEALTH HEALTH HMO HEALTH BENEFITS CONTRACT ACCIDENT SUPPLEMENT	HMO-2008-GH/HMO-G-ACC-01-308	2008
HEALTH BENEFITS CONTRACT PRESCRIPTION DRUG SUPPLEMENT	HMO-2009-ALL-G-RX/15/50/65-01-809	2009
HEALTH BENEFITS CONTRACT PRESCRIPTION DRUG SUPPLEMENT	HMO-2009-ALL-G-RX/10/Generic-01-809	2009

HMO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN SCHEDULE OF EXCLUSIONS	L&E-HMOBasic-109	2009
HMO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN ADDITIONAL BENEFIT SUPPLEMENT	HMO-2008-BAS-G-ABS-01-108	2008
HMO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN HEALTH BENEFITS CONTRACT	HMO-2009-BAS-G-HBC-01-109	2009
HMO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN HEALTH BENEFITS CONTRACT COVERAGE SCHEDULE	HMO-2009-BAS-G-HBC-01-109	2009
AMENDMENT TO HMO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN HEALTH BENEFITS CONTRACT	HMO-2009-BAS-G-AMEND-01-109	01/2009
HMO STANDARD HEALTH BENEFIT PLAN SCHEDULE OF EXCLUSIONS	L&E-HMOStandard-109	2009
HMO STANDARD HEALTH BENEFIT PLAN HEALTH BENEFITS CONTRACT	HMO-2009-STD-G-HBC-01-109	2009
HMO STANDARD HEALTH BENEFIT PLAN HEALTH BENEFITS CONTRACT COVERAGE SCHEDULE	HMO-2009-STD-G-HBC-01-109	2009
AMENDMENT TO HMO STANDARD HEALTH BENEFIT PLAN HEALTH BENEFITS CONTRACT	HMO-2009-STD-G-AMEND-01-109	01/2009
HMO Basic Limited Mandate Health Benefit Plan Offer of Supplemental Coverage	MK290-R0209	2009
HMO Basic Limited Mandate Health Benefit Plan Supplemental Coverage	MK291-R0209	2009
ROCKY MOUNTAIN GOOD HEALTH HEALTH MAINTENANCE ORGANIZATION HEALTH BENEFITS CONTRACT	HMO-2009-GH/HMO-G-HBC-01-109	2009
Application for Health Benefits For Groups with 2 or More Employees	MK69-R0209	2009
Application for Health Benefits For Groups with 2 or More Employees – Spanish	MK69-S-R0209	2009
Attestation for Business Group of One	MK73R0209	2009

Group Change Form	MK158-R0409	2009
Application for Conversion Coverage	MK181-R0209	2009
Open Enrollment Certification for Business Group of One	MK199-R0209	2009
Notice to Rocky Mountain Health Plans of Qualifying Event for Continuation of Coverage	MK210-R0209	2009
Request For Coverage For a Physically or Mentally Disabled Dependent Child	MK222-0209	2009
Group Disenrollment Form	MK231-R0209	2009
Employee Disenrollment Form	MK231-R0409	2009
Uniform Employee Application	MK453-R0209	2009
Uniform Employee Application - Spanish	MK453S-R0209	2009
Request for Enrollment of Common-Law Spouse	MK460-R0209	2009
Disclosure Notice for Small Employer Groups	MK57-R0209	2009

These forms were also reviewed for inclusion on the annual certified listing of forms filed with the Division for the period under review.

Rating

Rocky Mountain HMO provided copies of its rate filings with the Division for the period under examination. The examiners selected a random sample of health benefit plans from the population of plans issued and renewed during the examination period. The plans were reviewed and rated according to the filings. The examiners compared the rates determined in that process with the rates Rocky Mountain HMO showed in the files to determine accuracy and whether rating was completed in accordance with the filings as well as in compliance with Colorado insurance laws.

New Business Applications and Renewals

For the period under examination, the examiners selected a random sample of newly issued health benefit plans and renewals and reviewed them to determine compliance with Colorado insurance law.

Cancellations, Declinations, Nonrenewals, Rescissions

The examiners selected a random sample of cancelled or nonrenewed files from a single population of cancelled and nonrenewed policies for compliance with contractual obligations and Colorado insurance law. The examiners also reviewed the entire population of six (6) group plan declinations for compliance with Colorado insurance law.

Claims

To determine Rocky Mountain HMO's compliance with Colorado's law regarding timely payment of claims, the appropriate investigation and resolution of claims, accurate payment and correct notifications of payments and denials to members and providers, the examiners selected a random sample of claims from five (5) populations:

- Paid claims;
- Denied claims;
- Electronic claims paid, denied or settled more than thirty (30) days after receipt;
- Nonelectronic claims paid, denied or settled more than forty-five (45) days after receipt; and
- All claims paid, denied or settled more than ninety (90) days after receipt.

For those claims that were adjusted after the initial adjudication of the claim, regardless of whether the randomly selected sample claim was the original claim or an adjusted version of the claim, the examiners reviewed all versions of the claim to determine whether Rocky Mountain HMO errors in processing caused the claim to be resolved late when finally adjudicated.

Utilization Review

The examiners reviewed Rocky Mountain HMO's utilization management program including policies and procedures. The examiners also selected a random sample from the approved and denied utilization review populations and reviewed the entire population of fifteen (15) utilization review appeals, without sampling, for compliance with Colorado insurance law.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of eight (8) findings in which Rocky Mountain HMO was not in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

Operations and Management: In the area of operations and management, the examiners identified one (1) issue of concern:

Issue A1: Failure, in some instances, to retain records of certificates of creditable coverage issued to individuals whose coverage under individual plans terminated, as set forth in Colorado insurance law.

Complaints: In the area of complaints, no compliance issues were identified that met the reporting threshold to be included in this report.

Producers: In the area of producers, no compliance issues were identified that met the reporting threshold to be included in this report.

Forms: In the area of forms, the examiners identified one (1) issue of concern:

Issue E1: Failure of the Company's certificate of creditable coverage forms, in some instances, to include required information. *(This was a partial repeat of prior issue H2 in the findings of the market conduct examination report for 2004).*

Rating: In the area of rating, no compliance issues were identified that met the reporting threshold to be included in this report.

New Business Applications and Renewals: In the area of new business applications and renewals, no compliance issues were identified that met the reporting threshold to be included in this report.

Cancellations, Declinations, Nonrenewals, Rescissions: In the area of cancellations, declinations, nonrenewals, and rescissions, no compliance issues were identified that met the reporting threshold to be included in this report.

Claims: In the area of claims, the examiners identified five (5) issues of concern:

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay interest or penalty owed on claims not paid, denied or settled timely, as required by Colorado insurance law.

Issue J3: Failure, in some instances, to comply with Colorado insurance law regarding written explanations of what additional information is needed to determine liability and adjudicate a claim.

Issue J4: Failure to adopt and implement reasonable standards for prompt investigation of claims including refusing to pay claims or retracting claims payments without conducting a reasonable investigation of all available information.

Issue J5: Failure to correctly count the number of days to pay or deny claims and determine whether the claims were adjudicated late and if interest or penalty were owed.

Utilization Review: In the area of utilization review, the examiners identified one (1) issue of concern:

Issue K1: Failure to include the qualifying credentials of the physician or clinical peer who evaluated the appeal in the written notification of the decision.

FACTUAL FINDINGS

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure, in some instances, to retain records of certificates of creditable coverage issued to individuals whose coverage under individual plans terminated, as set forth in Colorado insurance law.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of § 10-1-109(1), C.R.S., states in part:

. . .

Section 4. Records Required for Market Conduct Purposes

A. Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to, company operations and management, policyholder services, claim's practices, rating, *underwriting*, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two prior calendar years. [Emphasis added.]

. . .

Section 5. Policy Records

A. *The following records shall be maintained*: A policy record shall be maintained for each policy issued. Policy records shall be maintained so as to show clearly the policy period, basis for rating and any imposition of additional exclusions from or exceptions to coverage. *If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination* and account records indicating a return of premiums, if any, *shall also be maintained.* Policy records need not be segregated from the policy records of other states so long as the records are readily available to market conduct examiners under this regulation.

B. Policy records shall include at least the following:

. . .

(2) Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, any termination notices, and any written or electronic correspondence to or from the insured pertaining to the coverage. *A separate copy of the record need not be maintained in the individual policy to which the record pertains, provided* it is clear from the insurer's other records or systems that the record applies to a particular policy and *that any data contained in the record relating to that policy,* as well as the actual policy, *can be retrieved or recreated; . . .*

. . .

Section 12. Records Usually Required for Examination

A. Records required for examination usually include, *but are not limited to*, the following, depending on the line of business; . . .

. . .

F. Underwriting and rating practices: annual rate filing, company rating plan and rates, disclosures, producer payments, credits, deviations, schedule rating, IRPM plans, expense/loss cost multipliers, statistical coding/reporting, premium audits, loss reporting, policy forms and filings, underwriting policies, procedures, and manuals, declinations/rejections, *cancellations/nonrenewals*, rescissions, policyholder records (applications, policy riders, correspondence, policy forms), guaranteed issue, pre-existing conditions and privacy of protected information [Emphases added]; . . .

Rocky Mountain HMO's record retention practices and procedures were not in compliance with Colorado insurance law in that, in some instances, the Company failed to retain records required for market conduct examinations. The examiners reviewed the entire population of sixty (60) individual coverage plan files for contracts that were cancelled or nonrenewed during the examination period. Of the sixty (60) files, Rocky Mountain HMO was unable to provide copies of ten (10) certificates of creditable coverage. Colorado insurance law requires carriers to retain copies of certificates of creditable coverage and Rocky Mountain HMO, in those instances, did not comply.

Recommendation No. 1:

Rocky Mountain HMO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 1-1-7 during the examination period**.** In the event Rocky Mountain HMO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HMO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has revised its practices and procedures to ensure that copies of all certificates of creditable coverage are retained for examination purposes in compliance with Colorado insurance law**.**

FORMS

Issue E1: Failure of the Company's certificate of creditable coverage forms, in some instances, to include required information. ***(This was a partial repeat of prior issue H2 in the findings of the market conduct examination report for 2004).***

Section 10-16-118, C.R.S., Limitations on preexisting conditions, states in part:

(1) A health coverage plan that covers residents of this state:

(a) (I) If it is a group health benefit plan, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than six months following the date of enrollment of the individual in such plan, or if earlier, the first day of the waiting period for such enrollment; except that, for business groups of one, a health benefit plan shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the date of enrollment of the individual in such plan. *A group health benefit plan may impose a preexisting condition exclusion or limitation only if such exclusion relates to a condition* (whether physical or mental), regardless of the cause of the condition, *for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding the date of enrollment* of the individual in such plan, or if earlier, the first day of the waiting period for such enrollment; except that a group health benefit plan shall not impose any preexisting condition exclusion in the case of a child that is adopted or placed for adoption before attaining eighteen years of age, or relating to pregnancy.

. . .

(b) *Shall waive* any affiliation period or time period applicable to *a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage*. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule.* [Emphases added.]

Colorado Insurance Regulation 4-2-18, Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions, promulgated under the authority of Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

. . .

Section 4 Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in

determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.* [Emphasis added.]

Section 5 Rules

A. Application of federal laws concerning creditable coverage.

1. *The method for crediting and certifying creditable coverage* for the purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., *shall be as set forth in the federal regulations incorporated below*.

2. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, *Colorado law shall prevail*.

3. *The following sections of the federal regulations*, adopted by the U.S. Department of Health and Human Services, *are hereby incorporated by reference and shall have the force of Colorado law*, in accordance with Section 24-4-103(12.5), C.R.S.

45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). *These sections concern the method for counting creditable coverage; requirements for providing certificates of creditable coverage* to those who were insured under group plans, *including the form and content of the certificates*, and requirements for providing certificates of creditable coverage to those who were insured under individual plans, *including the form and content of the certificates . . . .*

B. Colorado law concerning creditable coverage.

. . .

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, *any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.* [Emphases added.]

45 C.F.R. 146.115, Certification and disclosure of previous coverage, states in part:

(a) Certificate of creditable coverage – . . .

(3) Form and content of certificate –

(ii) Required information. The certificate must include all of the following: . . .

(F) Either –

(*1*) *A statement that an individual has at least 18 months* (for this purpose, 546 days is deemed to be 18 months) *of creditable coverage, disregarding days of creditable coverage before a significant break in coverage*, or . . . [Emphases added.]

45 C.F.R. 148.124, Certification and disclosure of coverage, states in part:

(a) Applicability –

. . .

(b) General Rules –

(1) Individuals for whom a certificate must be provided; timing of issuance.

. . .

(2) Form and content of certificate –

(i) Written certificate –

. . .

(ii) Required information. The certificate must include the following:

. . .

(E) Either one of the following:

(1) *A statement that the individual has at least 18 months* (for this purpose 546 days is deemed to be 18 months) *of creditable coverage, disregarding days of creditable coverage before a significant break in coverage* as defined in 45 CFR 146.113(b)(2)(iii). . . . [Emphases added.]

Colorado law requires that a carrier's certificate of creditable coverage must reflect that for plans subject to the jurisdiction of the Division, a significant break in coverage consists of more than ninety (90) consecutive days. This required definition must also clarify that for other plans (i.e., those not subject to the jurisdiction of the Division), a significant break in coverage may consist of as few as sixty-three (63) days.

Colorado insurance law defines a significant break in coverage as a period of consecutive days during all of which the individual did not have any creditable coverage. The period of consecutive days that constitutes a significant break in coverage is further defined as more than ninety (90) consecutive days.

Colorado insurance law provides that health benefit plans shall waive any limitation or exclusion of benefits due to an individual's preexisting condition if the individual had at least eighteen (18) months of continuous creditable coverage, disregarding days of creditable coverage before a significant break in coverage. Colorado insurance law incorporates provisions of 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2).

Colorado insurance law permits a group health benefit plan to impose a preexisting condition limitation or exclusion only if such limitation or exclusion relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding the date of enrollment of the individual in such plan, or if earlier, the first day of the waiting period for such enrollment. This six-month period is the look-back period.

Rocky Mountain HMO certificates of creditable coverage issued prior to October 31, 2009, were not in compliance with Colorado insurance law in that:

1. They did not include, in some instances, the required definition of a "significant break in coverage;"
2. They included, in some instances, a statement that a significant break in coverage was a time without coverage lasting ninety (90) days or more and referenced a 90-day break in coverage;
3. They incorrectly stated the look-back period as twelve (12) months before enrollment for business groups of one.

Rocky Mountain HMO's certificates of creditable coverage stated, in part:

> . . .
>
> Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions that existed before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." Preexisting condition exclusions can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months *(or 12 months for Business Groups of One)* before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or if there is a waiting period, the first day of your waiting period (typically, your first day of work). . . .
>
> . . .
>
> You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for *90 days or more* without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.
>
> > Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a *90-day break*. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan. [Emphases added.]

Form Name	Form Number	Edition Date
Certificate of Group Health Plan Coverage	EBM15R12/11/06	12/11/06
Certificate of Individual Health Plan Coverage	EBM15R12/11/06	12/11/06

Recommendation No. 2:

Rocky Mountain HMO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18 during the examination period**.** In the event Rocky Mountain HMO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HMO shall be required within sixty (60) days from the date this report is adopted to provide written evidence to the Division that it has revised its certificate of creditable coverage form used for both individual and group plans to include the specific definition of "significant break in coverage", correct information regarding what constitutes a "significant break in coverage" and the correct look-back period as required by Colorado insurance law. Within these sixty (60) days, Rocky Mountain HMO shall also provide the Division with specimen copies of all forms containing the revised provisions and provide the proposed date the forms will be put in use.

In the market conduct examination for the period of January 1, 2004 through December 31, 2004, Rocky Mountain HMO was cited for failure to include all required information in its certificates of creditable coverage in compliance with Colorado insurance law. The violation resulted in Item #21 of Final Agency Order O-07-005 that indicated the Company should revise its procedures to ensure that any required language, including that of a significant break in coverage, was included in all issued certificates of creditable coverage in compliance with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states in part:

. . .

(2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents.* A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

. . .

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically* and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.*

The examiners selected a random sample of 109 claims from a population of 21,501 electronic claims paid, denied or settled more than thirty (30) days after receipt by Rocky Mountain HMO during the examination period. Rocky Mountain HMO was not in compliance with Colorado insurance law in that sixty-one (61) of the 109 claims were clean claims that were not paid, denied or settled within thirty (30) days.

ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS - LATE

Population	Sample Size	Number of Exceptions	Total Error Percent
21,501*	109	61	56%

(*6% of all claims)

The examiners selected a random sample of 109 claims from a population of 8,994 electronic and nonelectronic claims paid, denied, or settled more than ninety (90) days after receipt during the examination period. Rocky Mountain HMO was not in compliance with Colorado insurance law in that ten (10) of the 109 claims reviewed were not paid, denied or settled within ninety (90) days. There was no indication of fraud and the examiners found no evidence of a fraud investigation in the files. Errors in Rocky Mountain HCO's earlier processing of those ten (10) claims required re-adjudication of those claims, causing the final adjudications to be late under Colorado insurance law.

CLAIMS PROCESSED OVER 90 DAYS - LATE

Population	Sample Size	Number of Exceptions	Total Error Percent
8,994*	109	10	9%

(*2% of all claims)

Recommendation No. 3:

Rocky Mountain HMO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Rocky Mountain HMO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HMO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has reviewed and modified its claims processing and quality controls to ensure that all claims are adjudicated within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay interest or penalty owed on claims not paid, denied or settled timely, as required by Colorado insurance law.

Section-10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states in part:

. . .

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically* and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. *If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).*

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.*

. . .

(5) (a) *A carrier that fails to pay, deny or settle a claim in accordance with paragraph (a) of subsection (4) of this section* or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, *shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.*

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant a civil action in accordance with section 10-3-1116, the carrier shall pay the

> penalty in this paragraph (b) to the insured or to the assignee. [Emphases added.]

The examiners selected a random sample of 109 claims from a population of 21,501 electronic claims paid, denied or settled more than thirty (30) days after Rocky Mountain HMO received them during the examination period. Rocky Mountain HMO was not in compliance with Colorado insurance law in that fifteen (15) of those 109 claims were clean claims that were paid late for which interest was owed but not paid.

ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS - INTEREST

Population	Sample Size	Number of Exceptions	Total Error Percent
21,501*	109	15	14%

(*6% of all claims)

The examiners selected a random sample of 109 claims from a population of 8,994 claims paid, denied, or settled more than ninety (90) days after Rocky Mountain HMO received them during the examination period. Rocky Mountain HMO was not in compliance with Colorado insurance law in that for ten (10) of the 109 claims a penalty was owed but was not paid.

CLAIMS PROCESSED OVER 90 DAYS - PENALTY

Population	Sample Size	Number of Exceptions	Total Error Percent
8,994*	109	10	9%

(*2% of all claims)

Recommendation No. 4:

Rocky Mountain HMO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Rocky Mountain HMO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HMO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has initiated changes to its claims processing procedures to ensure that interest or penalty is paid when owed for all claims that are not paid, denied or settled within the time frames required by Colorado insurance law.

Issue J3: Failure, in some instances, to comply with Colorado insurance law regarding written explanations of what additional information is needed to determine liability and adjudicate a claim.

Section-10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states in part:

. . .

(4) (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

. . .

(5) (a) *A carrier that fails to* pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or *take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.* [Emphases added.]

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers, promulgated under the authority of §§ 10-16-106.3(2), 10-16-109, and 10-1-109, C.R.S., states in part:

. . .

Section 6. Additional Information

A. A claim with all required fields is not considered "clean" if additional information is needed in order to adjudicate the claim. Carriers may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made. *When additional information is required the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form.* If information is being requested from a party other than

the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. *The specific information requested shall be requested within 30 calendar days after receipt of the claim form and identified for the provider upon request.*

. . .

F. When requesting medical records, carriers must identify the particular components(s) of the medical record being requested or indicate the specific reason for the request, e.g., progress reports for most recent three months, or records to establish the medical necessity of the treatment provided. The records requested must be related to the service/procedure of the claim and limited to the minimum amount of information necessary. *Requests for "all medical records" are not specific enough and would not be an appropriate request for claim adjudication.* [Emphases added.]

Rocky Mountain HMO, in some instances, was not in compliance with Colorado insurance law in its requests for additional information required to adjudicate claims (pending letters). In some instances, Rocky Mountain HMO didn't send pending letters when needed, sent them more than thirty (30) days after receipt of the claim, and requested "all" medical records without limiting the request to only those records related to the service/procedure of the claim and limited to the minimum amount of information necessary as required under Colorado insurance law.

Rocky Mountain HMO used two pending letter forms to request information regarding potential pre-existing conditions during the examination period; one was for members and the other was for providers. The pending letters were not in compliance with Colorado insurance law in that the letters requested information on *all* health care services rendered to the member over a period of months. Carriers may request only records related to the service/procedure of the claim. The information which may be requested is limited to the minimum amount of information necessary to adjudicate the claim.

The member pending letter Rocky Mountain HMO used during the examination period, CLM49R0608, stated in part:

. . .

. . . We will need information about the health care services you received on (date), **and** all health care services that have been rendered between (date) and (date).

If you cannot provide a Certificate of Creditable Coverage for this time period, please complete the statements below and return your response to RMHP by (date). **If a complete response is not returned by this date, claims related to treatment of medical conditions you experienced during the time period noted above may be denied by RMHP.**

Describe all MEDICAL CONDITIONS for which (name of Member) sought services between (date) and (date):

List all MEDICATIONS that have been prescribed or refilled for (name of Member) between (date) and (date):

> List all NAMES and PHONE NUMBERS of PHYSICIANS (Name of Member) saw between (date) and (date):
>
> List all ADVICE and TREATMENT PLANS given to (Name of Member) by a physician between (date) and (date): [Emphases original.]

The provider pending letter Rocky Mountain HMO used during the examination period, CLP65, stated in part:

> . . .
>
> Rocky Mountain Health Plans (RMHP) has received a claim for (Member Name), Date of Birth (date of birth). RMHP is unable to process this claim because the services may be subject to a pre-existing condition period. *In order to determine if the services are excluded by a pre-existing condition, RMHP is requesting copies of all medical records (including office visits, consults, x-rays, diagnostic testing, medication list and problems list) for this member from (date) to(date), if available.*

The examiners selected a random sample of 109 electronic claims from the total population of 21,501 electronic claims adjudicated more than thirty (30) days after receipt during the examination period. Of those, twelve (12) were unclean claims that needed pending letters sent to request additional information needed to adjudicate the claims. The examiners determined Rocky Mountain HMO was not in compliance with Colorado insurance law for eight (8) claims in that:

- Two (2) claims had no pending letters sent after receipt of the specific claim.
- One (1) claim had the pending letter sent late, more than thirty (30) days after receipt of the claim, and the pending letter requested all medical records, and
- Five (5) claims had pending letters that requested all medical records.

ELECTRONIC CLAIMS OVER 30 DAYS – PENDING PRACTICES

Population	Sample Size	Claims in Sample Needing Information	Number of Exceptions	Total Error Percent
21,501*	109	12	8	67%

(*6% of all claims)

Colorado insurance law requires carriers to request additional information needed to adjudicate a claim within thirty (30) calendar days after receipt of the claim; to make such request in writing; and to include a full explanation in the request of what is needed to resolve the claim. Colorado insurance law also requires carriers to be specific as to what information is required to adjudicate the claim, to limit requests for medical records to the minimum amount of information necessary and provides that requests for "all medical records" are not specific enough and are not appropriate requests for claim adjudication.

Recommendation No. 5:

Rocky Mountain HMO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., and Colorado Insurance Regulation 4-2-24 during the examination period. In the event Rocky Mountain HMO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HMO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that is has revised its claims procedures to ensure written requests for information are sent within thirty (30) days of receipt of a claim and the requests are in compliance with Colorado insurance law.

Issue J4: Failure to adopt and implement reasonable standards for prompt investigation of claims including refusing to pay claims or retracting claims payments without conducting a reasonable investigation of all available information.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

. . .

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

. . .

(III) *Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or*

(IV) *Refusing to pay claims without conducting a reasonable investigation based upon all available information, or*

. . .

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; or [Emphases added.]

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

. . .

(4) (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim,* including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, *the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b*), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, *all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

Section 10-16-413, C.R.S., Prohibited practices, states in part:

. . .

(2) Part 11 of article 3 of this title shall apply to health maintenance organizations, health care plans, and evidences of coverage except to the extent that the commissioner determines that the nature of health maintenance organizations, health care plans and evidences of coverage render such article clearly inapplicable.

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers, promulgated under the authority of §§ 10-16-106.3(2), 10-16-109, and 10-1-109, C.R.S., states in part:

. . .

Section 6 Additional Information

A. *A claim with all required fields completed is not considered "cle*an" *if additional information is needed in order to adjudicate the claim.* Carriers may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made. *When additional information is required the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form.* If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. *The specific information requested shall be requested within 30 calendars days after receipt of the claim form and identified for the provider upon request.*

B. Additional information requested must be related to information in the required fields of the claim forms, although the genesis of the request may be from other sources, . . . [Emphases added.]

Colorado Insurance Regulation 4-6-2, Group Coordination of Benefits, promulgated under the authority of §§ 10-1-109, and 10-16-109, C.R.S., states in part:

. . .

Section 4. Definitions

. . .

H. “Plan” means a form of coverage with which coordination is allowed or required. . . .
. . .

(3) "Plan" may include:

. . .

(g) The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and

. . .

J. "Secondary plan" means a plan that is not a primary plan. . . .

K. "This plan" means, in a COB provision, the part of the group contract providing health care benefits . . . which may be reduced because of the benefits of other plans. . . .

Section 6. Rules for Coordination of Benefits

. . .

C. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

. . .

Section 7. Procedure to be Followed by Secondary Plan

A. (1) . . . As each claim is submitted, the secondary plan must:

(a) Determine its obligation, pursuant to its contract;

. . .

(c) Determine whether there are any unpaid allowable expenses during that claim determination period.

. . .

B. *The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan* in the absence of this COB provision *and the benefits that would be payable for the allowable expenses under the other plans*, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, *exceeds the allowable expenses in a claim determination period.* In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses.

. . .

Section 9. Miscellaneous Provisions

A. *A secondary plan* that provides benefits in the form of services *may recover* the reasonable cash value of the services from the primary plan, *to the extent that benefits* for the services are covered by the primary plan and *have not already been paid by the primary plan*.

B. (1) A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits . . . on the following basis:

. . .

(2) If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

(3) . . . In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. . . .[Emphases added.]

Rocky Mountain HMO was not in compliance with Colorado insurance law in that its claims practices included paying or denying a claim, in some cases, without conducting a reasonable investigation to determine the Company's liability.

When a claim was submitted with an indicator code showing it was employment related, the claim was denied without determining whether the treatment or procedure actually was covered by workers' compensation coverage. When a claim was submitted with an indicator code showing it was auto accident related, the claim was denied without determining whether auto medical payments coverage was applicable to the treatment or procedure on the date of service it was provided.

Rocky Mountain HMO included an explanation of this procedure for claims handling in the document "RMHP's Third Party Liability Case Development and Research":

. . .

When an individual claim is submitted with a clear indication (this indication is the use of an "employment" indicator code) from the provider that the services provided are work related, that claim will be denied, as services such as these are not a benefit of RMHP's plans.

When an individual claim is submitted with a clear indication (this indication is the use of an "auto accident") from the provider that the services provided are automobile (auto) related, that claim will be denied, as auto medical payments coverage is primary over RMHP coverage.

Colorado insurance law requires carriers to conduct a reasonable investigation before denying a claim. Any procedure that allows denying a claim without a reasonable investigation is not in compliance with

Colorado insurance law.

In addition to denying and, in some cases, paying claims without investigation, one part of the claims standards Rocky Mountain HMO adopted and implemented was the use of My Socrates Third Party Liability ("TPL" or "My Socrates") investigation software. My Socrates software was built with rules based on diagnosis codes that the developers believed depicted the likelihood of an injury or an accident and the possibility that a third party may be liable. Claims that were finalized (paid or denied) were extracted and, in some cases, identified and imported by My Socrates investigation software. A case file of those claims was created by My Socrates investigation software and all claims Rocky Mountain HMO received for that member from that point forward were appended to the case file regardless of diagnosis code. However, non-injury related claims data were housed in the "inactive" section of the case, whereas the injury related claims data were housed in the "active" section of the case. Whether a claim was injury related was determined by the diagnosis codes in the My Socrates rules that were the basis for the creation of the case file.

When Rocky Mountain HMO's amount paid for claims with the diagnosis code identified in the My Socrates rules reached a threshold of $500, a financial recovery team member conducted a TPL investigation to determine the identity of any third party potentially liable for the claims included in the case file.

In some cases, initial claims adjustment decisions of "finalized" claims were reversed when the TPL information was received. Claims Rocky Mountain HMO denied without first conducting reasonable investigations were, in some cases, paid because the Company learned there was no applicable third party involved and the denials were in error. Claims paid without investigations were retracted, in some cases, when Rocky Mountain HMO's TPL investigation revealed that a third party was or had been involved in the claim or similar claims.

The retractions of payments, in some cases, were made without Rocky Mountain HMO first determining whether the third party identified had also paid the claims which Rocky Mountain HMO had paid, making the Rocky Mountain HMO payment a duplicate. Unless there was an overpayment via a duplicate payment, retracting the payment was not in compliance with Colorado insurance law.

The Company's Claims Processing Manual in the section titled "COB and TPL", states in part:

> Effective 11/2008, RMHP successfully implemented a new remediation process that will be supported by My Socrates, Inc. effective 12/2008. With new legislation, RMHP historical process of pursuing third parties before paying claims was converted to a pay-then-pursue process of claims review.
>
> The TP32 and TP60 claims pend process became obsolete and all claims review is done behind the scenes from the normal claims examining functions.

Rocky Mountain HMO explained that the statement in the Company's Claims Processing Manual that the claims "pend process" for certain claims (TP32 and TP60) became obsolete and "all claims review is done behind the scenes" referred to the TPL investigation process as opposed to the normal claims payment criteria review. However, requests for retraction of claims or to "pick up" and pay claims, in some cases, had "TPL" as the contact and included the notation "TPL review completed - Yes". The retracted claims, in some cases, were later adjusted a second time to correct the first adjustment the TPL team requested. This occurred, in some cases, because Rocky Mountain HMO processed the first TPL requests without investigating to determine whether there had been a duplicate payment before retracting

the payment.

Rocky Mountain HMO's Third Party Liability Case Development and Research document stated that the financial recovery team focused on TPL investigations and did not review claims or make individual claims payment decisions. Rocky Mountain HMO stated that was correct. Nevertheless, the financial recovery team, TPL, requested adjustments to claims. Those adjustment requests and subsequent adjustments without further investigation indicated the TPL investigation results were integrated with the overall claims investigation and adjustment process.

Rocky Mountain HMO substituted its pay then pursue process of claims review, initiated after claims with certain diagnosis codes were originally "finalized", for the required initial investigations of claims. This was true for claims denied when submitted with employment or auto accident related indicators and for claims paid as indicated in Rocky Mountain HMO's claims manual. The examiners observed the TPL process was an active part of the process Rocky Mountain HMO adopted and implemented for claims investigation and resolution. That process included a standard of paying or denying claims without first conducting reasonable investigations.

Recommendation No. 6:

Rocky Mountain HMO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-3-1104, 10-16-106.5 and 10-16-413, C.R.S., and Colorado Insurance Regulations 4-2-24 and 4-6-2 during the examination period. In the event Rocky Mountain HMO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HMO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that is has revised its claims procedures to require completion of a reasonable investigation to determine liability before denying a claim or retracting a claim payment. Within these thirty (30) days, Rocky Mountain HMO shall also provide the Division with copies of any claims guidelines and TPL investigation guidelines revised to comply with Colorado insurance law.

Issue J5: Failure to correctly count the number of days to pay or deny claims and determine whether the claims were adjudicated late and if interest or penalty were owed.

Section 10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states in part:

. . .

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.*

. . .

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.*

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant

> a civil action in accordance with section 10-3-1116, the carrier shall pay the penalty in this paragraph (b) to the insured or to the assignee. [Emphases added.]

In some cases, Rocky Mountain HMO was not in compliance with Colorado insurance law in that its process for determining the date a claim was paid for the purpose of determining whether a claim was paid timely did not properly count the number of days to pay or deny the claim.

Rocky Mountain HMO calculated the number of days to pay from the date the check was issued or printed rather than the date the check was mailed. The Company's usual process was to accumulate all claims payments authorized during the week into a batch run that began on Friday night and ran through some time on Saturday. The checks that ran in that batch were then mailed the following Monday along with vouchers/remittances sent to providers and explanations of benefits sent to members. Rocky Mountain HMO built one day into its counting process to reflect that the batch run began on Friday and finished on Saturday. Its records showed the claims paid on Saturday.

Because the claims checks were mailed on the following Monday, Rocky Mountain HMO's process should have built in a total of three days from the date the batch began to run to accurately record the date the checks were mailed. In addition, no adjustment was made to the number of days added in the counting process for holidays that occurred on Mondays, Fridays, or Saturdays. That also impacted either the day the batch run began or the day the checks were mailed, or both.

Accurately counting and recording the number of days to pay claims is material to determining whether claims are paid timely or not and whether interest or penalty is owed on claims payments as well as the amount of interest when it is owed.

Recommendation No. 7:

Rocky Mountain HMO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Rocky Mountain HMO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HMO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has revised its systems and procedures to ensure that the number of days to adjudicate claims and the amount of interest or penalty owed in the case of a late payment is calculated correctly.

UTILIZATION REVIEW

Issue K1: Failure to include the qualifying credentials of the physician or clinical peer who evaluated the appeal in the written notification of the decision.

Section 10-16-113, C.R.S., Procedure for denial of benefits – internal review – rules, states in part:

. . .

(3)(b)(V) The first-level appeal shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer; . . .

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

. . .

Section 4. Definitions

. . .

D. *"Clinical peer" means a physician or other health care professional who holds* a nonrestricted license in a state of the United States and *in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.* [Emphasis added.]

. . .

Section 10. First Level Review

. . .

G. Notification Requirements

1. A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frame provided in Paragraph 2. or 3.

. . .

I. The decision issued pursuant to Subsection G. shall set forth in a manner calculated to be understood by the covered person:

1. The name, title and *qualifying credentials* of the physician evaluating the appeal, and the *qualifying credentials* of the clinical peer(s) with whom the physician consults . . . [Emphases added.]

The examiners reviewed the entire population of ten (10) first level appeals cases received during the examination period. In seven (7) of these cases, Rocky Mountain HMO was not in compliance with Colorado insurance law in that it failed, in the written notification letter, to provide the qualifying credentials of the physician and clinical peer(s) who evaluated the first level review.

FIRST LEVEL APPEALS – QUALIFYING CREDENTIALS

Population	Sample	Number of Exceptions	Total Error Percent
10	10	7	70%

Recommendation No. 8:

Rocky Mountain HMO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-113, C.R.S., and Colorado Insurance Regulation 4-2-17 during the examination period**.** In the event Rocky Mountain HMO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HMO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has revised its first-level appeal notification letters to include the qualifying credentials of the physician and clinical peer(s) as required by Colorado insurance law**.**

SUMMARY OF ISSUES AND RECOMMENDATIONS	Rec. No.	Page No.
OPERATIONS AND MANAGEMENT		
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CONTRACT FORMS		
Issue E1: Failure of the Company's certificate of creditable coverage forms, in some instances, to include required information. *(This was a partial repeat of prior issue H2 in the findings of the market conduct examination report for 2004).*	2	26
CLAIMS		
Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.	3	29
Issue J2: Failure, in some instances, to pay interest or penalty owed on claims not paid, denied or settled timely, as required by Colorado insurance law.	4	31
Issue J3: Failure, in some instances, to comply with Colorado insurance law regarding written explanations of what additional information is needed to determine liability and adjudicate a claim.	5	34
Issue J4: Failure to adopt and implement reasonable standards for prompt investigation of claims including refusing to pay claims or retracting claims payments without conducting a reasonable investigation of all available information.	6	41
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Examination Report Submission

State Market Conduct Examiners

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Submit this report on this 27th day of September, 2012 to:

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